Nutrition Rounds—Oncology Rotation
Krista Maruschak
7/30/2015

Introduction	JM Patient is a 24 year old female with history of GERD, hypothyroid, seizures and AML s/p induction chemotherapy and subsequent 2 cycles consolidation therapy with HiDAC (last 6/30) now with bone marrow biopsies showing remission was admitted 7/6 to the MICU for fevers/nausea and vomiting 2/2 sepsis in the setting of neutropenia. On 7/7 patient experienced a seizure attributed to either CNS involvement of infection or recently diagnosed brain lesions. 7/10 was transferred to NSICU for further management where a Dobhoff tube was placed due to NPO status since admission 2/2 altered mental status. 7/19 patient removed DHT and was also cleared by SLP for a pureed diet with thin liquids. Patient transferred to general medical floor 7/20, and 7/21 was cleared for a mechanical soft diet with thin liquids per SLP—following transfer and diet advancement DHT was not replaced.
Hospital Day 18 (Friday, 7/24/1015)	
Nutrition Assessment	1. Anthropometrics -Ht: 154.9 cm Admit wt: 45 kg Current wt: 44 kg BMI: 18 IBW: 45 kg %IBW: 99% -Weight history: Significant unintentional weight loss of 14 lbs (14%) within the last 3 months Wt Readings from Past Encounters: 06/30/15 44.044 kg (97 lb 1.6 oz) 06/08/15 43.999 kg (97 lb) 06/02/15 42.5 kg (93 lb 11.1 oz) 05/21/15 44.09 kg (97 lb 3.2 oz) 05/17/15 45.3 kg (99 lb 13.9 oz) 04/27/15 46.539 kg (102 lb 9.6 oz) 04/24/15 46.267 kg (102 lb) 04/22/15 46.584 kg (102 lb 11.2 oz) 03/16/15 50.349 kg (111 lb) -Physical assessment: Evident fat and muscle wasting -SGA: C-Severe malnutrition -Skin Integrity: Intact 2. Client History a. Medical/surgery history -Acute myeloid leukemia diagnosed 3/2015 -C-section 2010 b. Nutritionally Significant Medications potassium chloride, magnesium L-lactate (MAG-TAB SR), ondansetron (ZOFRAN) PRN, prochlorperazine (COMPAZINE) PRN, LIPOSOMAL amphotericin B (AMBISOME), meropenem (MERREM), traMADol (ULTRAM) PRN, vancomycin (VANCOCIN)—diagnosed with C diff 7/7, posaconazole (NOXAFIL), levothyroxine (SYNTHROID) c. Social History - Adequate with mother usually at bedside -Decreased functional status from baseline due to current deconditioning

<table>
<tr><td></td><td>3. Labs
<table>
<tr><td colspan="2">7/24</td></tr>
<tr><td>Na: 139</td><td>BUN: 9</td></tr>
<tr><td>K: 3.4</td><td>Cr: 0.47</td></tr>
<tr><td>Cl: 107</td><td>Glu: 99</td></tr>
<tr><td>CO2: 25</td><td>Ca: 8.1</td></tr>
<tr><td>Phos: 2.9</td><td>Mg: 1.8</td></tr>
</table>
4. Food/Nutrition History
a. Food and nutrition prior to admit: Decreased intake due to chemotherapy treatments and history of neutropenic fevers
b. Current diet order: Mechanical soft with thin liquids
c. Food allergies: None
5. Estimated Nutrition Requirements
Calculating weight: 44 kg
Energy: 1540 kcal (35 kcal/kg)
Protein: 66 g (1.5 g/kg)
Fluid: 1540 mL (35 mL/kg)
6. GI symptoms
- Anorexia
7. Intake:
-0-25% over past 3 days--patient only eating 25% of yogurt, has stated dislike of hospital food</td></tr>
<tr><td>Nutrition Diagnosis/PES</td><td>Evident protein-energy malnutrition related to poor appetite/intake in setting of cancer as evidenced by weight loss, muscle and fat wasting</td></tr>
<tr><td>Nutrition Intervention</td><td>• Continue current mechanical soft with thin liquids diet order
• Provide snacks/supplements PRN per patient request
• Recommend Dobhoff re-placement + bridle to prevent self-removal of tube if intakes do not improve--will discuss with NP</td></tr>
<tr><td>Nutrition Monitoring and Evaluation</td><td>• Patient to increase meal consumption to at least 50-75% of meals during admission</td></tr>
<tr><td>Initial Impression</td><td>Patient is a 24 year old female with history of GERD, hypothyroid, seizures and AML s/p 2/3 cycles induction HiDAC (last 6/29) admitted for fevers/nausea and vomiting 2/2 sepsis in the setting of neutropenia. Patient is at increased nutrition risk due to evident fat and muscle wasting and current lack of intake. Current diet order of mechanical soft with thin liquids is appropriate per SLP recommendations. Patient is not consuming adequate calories and protein to meet needs per intake records. Patient fatigued during visit however, did endorse poor appetite and declined any snacks at this time. Recommend replacing Dobhoff tube if intakes continue to not meet needs. Will continue to monitor to ensure adequate intakes are being met.</td></tr>
<tr><td colspan="2">Hospital Day 21 (Monday, 7/27/1015)</td></tr>
<tr><td>Events Since Last Visit</td><td>-Continued lack of intake (0-25% meals consumed)
-Labs
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<tr><td colspan="2">Hospital Day 23 (Thursday, 7/30/1015)</td></tr>
<tr><td>Events Since Last Visit</td><td>-SLP cleared patient for general diet with thin liquids 7/28
-Continued refusal of adequate PO intake
-DHT placed 7/28
-Tube removed that evening, replaced and confirmed 7/29
-Goal Tube Feeding: Promote with Fiber @ 70 ml/hr over 22 hours (holding 1 hour before and after synthroid)
Goal Tube Feedings Provides:
Total kcal: 1540 kcal
Kcal/kg: 35 kcal/kg
Total Protein (gms): 97 gm
gm Protein/kg: 2.19 gm/kg
mL Free Water From Formula : 1278 ml
-Experienced some nausea with current tube feed infusion, resolved with Zofran administration
-Labs
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Nutrition Intervention	• Continue tube feeds: Promote with Fiber @ 70 ml/hr over 22 hours (holding 1 hour before and after synthroid) • Continue pleasure feeds with general diet as tolerated per SLP 7/28 • Replace Mg, K, Phos as needed to remain WNL • Nausea: Continue Zofran and Compazine PRN
Nutrition Monitoring and Evaluation	• Patient will continue to tolerate goal tube feeding
Final Impression	Patient is a 24 year old female with history of GERD, hypothyroid, seizures and AML s/p 2/3 cycles induction HiDAC (last 6/29) admitted for fevers/nausea and vomiting 2/2 sepsis in the setting of neutropenia. Patient remains at nutrition risk due to evident fat and muscle wasting and inability to meet adequate calorie and protein needs PO. Patient with poor oral intake due to refusal of meals and disinterest in eating for several days, DHT placed 7/28. Tube feeds will provide 100% of nutrition needs. Patient reported nausea with current tube feeding infusion, with symptoms resolving following Zofran administration. Discussed with patient's mother about transitioning to bolus feeds when PO intake increases. However, as of now will continue continuous tube feed order. Recommend continue general with thin liquids (per SLP) PO diet per patient request of food and patient's mother reported she will continue to encourage patient to consume PO intake as tolerated. RD following closely for tolerance to tube feeds